III

ADMINISTRATIVE COSTS
FOR THE MONTH OF _____, 20___

Budget and Contracts

Contract ID No.: _____

_____
Provider Agency Name

Section I Object of Expenditure (1)	(2) Current Expense	(3) State Use Only	(4) Total Current Expenses	(5) YTD Expenses	(6) Approved Budget	(7) Unexpended Balance
A. Provider Salaries						
B. Provider Fringe Benefits						
C. Provider Staff Development						
D. Provider Travel						
E. Equipment Purch.-Tangible Prop.						
F. Transportation Recipient						
Other Cost						
Salary/Fringe Cost						
G. Medical Supplies & Expenses						
H. Cost of Space-Non-Residential						
I. Room & Board-Residential						
J. Service Payments						
K. Other (list individual objects)						
L. Indirect Cost						
TOTAL	0	0.00	0.00	0.00	0.00	0.00

Section II-Certification

As chief executive officer of the contracting organization, I hereby certify that the cost or units billed on this form were incurred and delivered according to the provisions of the contract. I further certify that any required matching expenditures have been incurred, and that to the best of my knowledge and belief we have complied with all laws, regulations and contractual provisions that are conditions of payment under this contract.

_____ _____
Authorized Provider Agency Official Signature | Date

_____ ( )_____
Printed Name of Person Responsible for Completion of Report | Telephone Number (include area code)

DSS-1571S PART III (Rev. 11-99)

DSS Contract Administrator Name _____ **249**_____

Telephone Number ( )_____ **Account #**_____

Date: _____ **Center #** _____